Priory Rehabilitation Services Limited

The Vines

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on the 1 and 2 June 2016 and was unannounced. The Vines is a care home registered to provide accommodation and personal care for a maximum of seventeen people. The Vines specialises in the treatment of acquired brain injury and neuro-rehabilitation for adults. The service aims to promote independence and help each resident back into the community. People required a range of support in relation to their support needs and some people had limited mobility. At the time of the inspection there were fifteen people living in the home.

The Vines had been without a registered manager since December 2015. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The previous manager had left and de-registered. A replacement had been found but was not able to commence employment. Interim management had not been put in place and team leaders were covering the registered manager role in addition to their daily duties and responsibilities. A new manager had been recruited and was due to start work the week following inspection. The regional manager told us that the newly appointed manager would be registering with CQC as soon as they had completed their initial induction and training.

A safeguarding meeting had taken place 26 February 2016 and social services had identified areas of concern that required improvement and an action plan had been put in place for the care home to address these concerns. The action plan had not been completed in a timely way and the care provided was not consistently personalised and behaviours which challenged were not appropriately managed.

Care plans and risk assessments did not consistently contain guidance for staff on how to respond to and manage behaviours which challenge.
Activities were not planned or provided in a personalised way. People did not have individual activity plans which identified their likes, dislikes and preferences for activities.

Medicines were not always managed safely. There was a potential risk to people that they may exceed the maximum daily dose of paracetamol because it was also a homely remedy. Staff did not follow controlled drugs procedures.

The complaints policy on display was not current, it had incorrect contact information and some contact details were missing.
There were robust recruitment practises in place to ensure that staff were safe to work with people.
Policies and procedures were available for staff to support practice. There was a whistle blowing policy and staff were aware of their responsibility to report any bad practice.
Some staff had built caring relations with people and had a good knowledge of their life history which

enabled them to provide personalised care.

People's rooms were personalised and decorated to the persons preferred choice. People were able to attend monthly meetings to discuss agenda items including activities, food and events.
Pre-admission assessments were completed by the consultant psychiatrist and a general assessment of all aspects of care and support needs. People were supported to maintain their health and well-being. People had access to health and social care professionals.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines were not always managed safely. Staff were not able to explain the reason and purpose of medicines to people. Medicines were not being appropriately recorded.

The provider had carried out appropriate employment checks on staff to ensure they were suitable and safe to work with people at risk. Accidents, incidents or near misses were appropriately recorded and monitored.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were being supported by staff who did not have the training and knowledge to be able to meet their needs.

Staff did not have a good understanding of the Mental Capacity Act.

People were being referred to health professionals in a timely manner.

Is the service caring?

Requires Improvement

The service was not caring.

Staff did not respect people's dignity. Staff shouted to each other across the room when people were doing activities or eating meals.

People with communication and sensory needs were not supported to express their views or preferences.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People and visitors did not have access to accurate information to be able to report complaints. The complaints policy on display was not current, it had incorrect contact information and some contact details were missing.

People were not offered activities based on their likes and preferences. Activities were not planned or provided in a personalised way.

Weekly multi-disciplinary team meetings took place to discuss and review the needs of all the residents.

Is the service well-led?

Inadequate

The service was not well led.

The organisation and management had not provided sufficient support to staff in the absence of a registered manager.

The organisation and management had not been able to carry out the safeguarding action plan by the agreed completion dates.

The provider did not have effective systems in place to carry out health and safety checks.

The Vines

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 and 2 June 2016 and was unannounced. The inspection was carried out by two inspectors and a specialist advisor with experience of acquired brain injury and neuro-rehabilitation services.

Before the inspection, we had not asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. A current PIR was not available and we took this into account when we inspected the service and made the judgements in this report. We reviewed the previous inspection report and PIR. We also reviewed information which had been shared with us by the local authority and other people, and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met and spoke with the three people who lived at the service to find out about their experiences of living at the home. We carried out observations in communal areas and looked at care documentation to see how they had their care provided.

We looked at three care plans. Looking at care documentation is an important part of our inspection, as it allows us to capture information about people receiving care. We also looked at daily records, risk assessments and associated daily records, charts and Medicine Administration Records (MAR). We read diary entries and other information completed by staff, policies and procedures, accidents, incidents, quality assurance records, recruitment, meeting minutes, maintenance and emergency plans. Recruitment files were reviewed for two staff and records of staff training, and supervision.

We spoke with 10 staff including eight care staff, the head of quality assurance and regional manager. We observed staff interactions with people and observed care and support in communal areas. We looked at

records held in the home. These included three people's care records, three risk assessments, two behaviour charts, staff rotas, meeting minutes, policies and procedures. We spoke with two relatives of people who lived at the service after the inspection.

A previous inspection took place on 6 November 2013; the service had met the standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service safe?

Our findings

People felt safe living at the home. One person told us "Now I am safe. I can ask someone for help they won't tell me I am stupid or tell me off ." and another person said "I am very happy here. I feel safe."

Peoples' medicines were not always managed safely. There was a risk to people who were prescribed paracetamol as pain relief because it was also used as a homely remedy for all residents. A person may exceed the prescribed daily dose of paracetamol because there was not a system in place to check records of homely remedies against prescribed medicine. Staff did not follow correct procedures for administering and recording controlled drugs. The controlled drug book stated that four patches remained in stock, however only three were present in the cabinet. The staff member administering the next dose had also signed the MAR sheet but on recording this in the controlled drugs book had not reconciled this entry with the number of patches remaining in the box. The staff took immediate action when this was identified. They established that the patch had been administered but not recorded, and the entry was corrected to reflect this.

Due to the health conditions of some people, emergency medicine had been provided. There were increased risks to the person of long term damage to their health because there were no members of staff trained administer the medicine if the situation arose. One staff member told us in the event that the person needed their emergency medicine emergency services would be called to administer the medicine.

Some people did not understand the purpose of the medicines they were given. The care plan for one person stated, 'Staff may need to explain why I am taking my medication'. One member of staff who was trained to administer medicine was not able to identify why the person was taking the medicine, the properties or side effects of the medicine. This meant the person could not be reassured why they were taking the medication as stated in the care plan.

The provider had failed to maintain safe medicine procedures, storage and recording, which is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were safe medication administration systems in place and people received their medicines when required. There was photo ID for all service users in their medicines files, and known allergies were clearly stated. There was a list of staff who were trained in medicines administration and diabetes management with specimen signatures and initials. MAR sheets were completed appropriately. Temperature monitoring charts for the clinic room and the medication fridge were in place and up to date, recorded temperatures were within a safe range.

There were not robust arrangements in place to maintain kitchen hygiene. The housekeeper was responsible for the weekly kitchen deep clean but we were told, "They are on leave today and no one is going to cover their duties." The fridge included eight out of date food items including fresh produce. The team leader told us, "The chef isn't here at tea time so whoever cooks should be doing the checks on produce." This had not been done. All out of date food was immediately disposed of during the inspection.

We recommend that the service seek advice and guidance from a reputable source on food safety management procedures and food hygiene regulations.

There were arrangements in place to keep people safe in an emergency. Staff knew where to access the information including on call arrangements and contact numbers. Contingency plans were in place and included details of emergency accommodation.

Team leaders were not able to show how they identified the number of staff on shift that were needed to meet the needs of people at the service. They told us, "We just know it has to be six and six because it always has been." We saw three people individually approach one member of staff who asked them to come back later because they were busy writing notes. There was no evidence to suggest a link between risk assessments and changes in people's needs being used to identify the number of staff required.

The provider did not have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service and keep them safe at all times. This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected against the risks of potential abuse. Safeguarding training was overdue for 7 out of twenty staff, one member of staff said "There hasn't been any safeguarding training since last year." The staff files showed that safeguarding discussions did not consistently take place, in one record a discussion about staff conduct took place instead, another file did not include a safeguarding discussion and where discussions had taken place they did not cover signs of abuse and how to report concerns. Staff said "We always ring the safeguarding team to report unexplained bruises" and "When people make an allegation I always record and report it to the senior on duty." People who lacked capacity to manage their finances were protected from financial abuse by having financial appointees through the Court of Protection. Staff were familiar with the whistleblowing procedure "Whistleblowing is for safeguarding adults, things I think are being done wrong" and "The whistleblowing policy is on the board if I have concerns I would go to the team leader and if I couldn't I would go higher."

An action plan was in place as the outcome of a safeguarding meeting with social services. It had identified concerns around isolation used as a punitive measure; unreported injuries sustained; poor management of falls; poor management of diabetes.

People continued to be at risk of being isolated from others as a method of managing behaviours which challenged. The first step in one persons' behaviour management care plan was, 'Staff are to ask me to go to my room' while the redirection techniques were a secondary option. Staff confirmed that they did ask the person to go to their room before using redirection techniques. There was no evidence of how the decision to manage the person's behaviour had been reached, or whether the methods they were using were effective. The team leader's said that redirection techniques should be the first response to help to manage the person's challenging behaviour and they could not explain why removing the person from the situation to go to their room was the first action identified in their behaviour management care plan.

People were not protected from abuse and improper treatment. This is a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Behaviour support plans were in place but the purpose of some charts were unclear and they did not include guidance for staff on how to respond. The team leaders were able to explain that two behaviour charts we saw were an outcome of a multi-disciplinary team meeting. The behaviour charts recorded only the type and frequency of behaviour and did not contain enough information to analyse the triggers and if

methods used to manage the behaviour were effective. The lead psychologist used the behaviour charts to identify appropriate methods of support for the person but this was not reflected in the notes or the support plan. This meant there was a potential risk to people not receiving the support they required in a timely way .

Staff did not always have access to personalised methods of behaviour management when supporting people. Care plans and risk assessments had detailed information about people's behaviours which challenged but they did not always contain guidance for staff on how to respond to and manage challenging behaviours. For example, there was a risk assessment in place for one person who had an eating disorder, and this provided good guidance for how to support the person appropriately. However a support plan for another person said "maintain effective communication and divert" but did not provide enough detail for staff on how to do this.

The above is a failure to appropriately identify and manage risks relating to the health, safety and welfare of people using the service. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents, incidents or near misses were recorded and monitored. We saw records of completed accident/incident forms which included reporting of falls, this information had been transferred to the online database. The information on the database was reviewed to identify emerging trends and patterns and reduce risks to people. Where one person was experiencing recurring falls, action had been taken to provide a bed sensor and a falls pendant and for staff to accompany the person to their room in the evening as this was the time when falls were most likely to occur.

The risk of harm to people with diabetes were appropriately managed. A "traffic light" system and clear reporting process had been implemented. It clearly stated what action staff should take depending on the blood glucose measurement, including emergency responses. There was a blood glucose monitoring chart for all service users with diabetes including the site of insulin injections to ensure adequate rotation to reduce the risk of skin damage.

The service followed safe recruitment practices. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with adults. Records seen confirmed that staff members were entitled to work in the UK.

Requires Improvement

Is the service effective?

Our findings

People and their relatives had mixed views about the skills and caring nature of staff. People we spoke to said "The staff are very dedicated and know how to support me" and "The staff know me well and help when I need it." One person's relative told us that staff aren't familiar with their relatives needs saying, "When I ask how they are staff say they haven't complained [of pain] but they wouldn't be able to [because of memory impairment]." A visitor told us staff were caring but didn't seem to be very knowledgeable about the specific needs of people with an acquired brain injury.

People were supported by staff who did not receive adequate supervision (one to one meetings) with their line manager. Staff told us supervisions were, "Normally monthly but they have lapsed." There were no records of supervision during 2016 in the staff files we saw. Where supervisions had taken place there was no evidence of discussion about staff's experiences with the people they cared for or support to help staff improve their practice. The supervision notes either did not identify or did not address actions to resolve issues that had been raised. One member of staff told us, "If I have any problems I know I can go to the team leaders, I wouldn't wait for supervision to bring something up". However, the team leaders stated they had not received any training to conduct supervisions in the absence of a registered manager.

People were being supported by staff who had did not have the opportunity to maintain their skills and knowledge. Staff files were checked for evidence for records of induction, supervision and training. Staff inductions focused on 'housekeeping' tasks and did not demonstrate how new staff were introduced to people or oriented in how to meet peoples care needs. Staff told us, "Induction was good; they showed me around and I shadowed which was good." There was evidence that shadowing took place but did not establish if competency levels had been achieved or signed off. The team leader said that people's feedback on new staff is gathered but was not recorded.

Staff files did not contain records of training undertaken. Staff training records were in the process of being transferred to a database and staff certificates of training were being checked but this was in progress. On the day of inspection they were unable to demonstrate what training staff had received. It was not possible to establish if staff had the right skills and training to provide effective care.

Staff received training through online modules or attended mandatory training. Training needs were discussed in supervision but there was no plan of action or dates set to achieve training or of competency assessments to establish if the training had been effective. Staff told us "I have asked and keep asking in supervision for specific training". When the staff files were checked the reason why the staff member had not been put forward was that the team leader did not feel the staff member was ready for this training without an explanation for this decision.

Staff were not familiar with people's individual brain injuries or neurological conditions. Acquired brain injury training was due for eighteen out of the twenty staff. Staff were unable to describe the types of support people required in relation to their specific needs. When asked about a person's specific needs a staff member told us "We usually take the information about their condition with us to appointments." The

regional manager told us "Acquired brain injury (ABI) overview training is going to take place, we have an ABI strategy plan for 2 week distance learning workbook."

Staff did not always have the training and knowledge they needed to meet people's needs and ensure their safety. The chef referred to a folder of people's dietary preferences and special requirements. The folder did not contain guidance for the chef to follow if menu choices were not suitable when people with diabetes had high or low blood sugar. The chef had to rely upon staff providing this information verbally. People were weighed monthly and food monitoring charts were in place when appropriate. People were referred to relevant health professionals when weight loss or weight gain was identified.

The above is a failure to ensure suitable numbers of suitably trained, qualified and competent staff which is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff had received training on the mental capacity act. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed.

However, not all staff had a clear understanding of the principles of the MCA. One member of staff was able to accurately summarise the mental capacity act saying, "Everyone is deemed to have capacity until proven otherwise. When they are unable to make choices is when a best interest decision is put in place." Other staff stated "It's whether someone has the capacity to make decisions", "It is about people who can't make a decision or make a safe decision" and "A mental capacity assessment is to find out if they have the capacity to do things" but they were unable to state the underpinning principles of the mental capacity act. The team leaders and regional manager said this training was in the process of being arranged. There was a record of staff who had been put on the waiting list to receive training from East Sussex local authority.

When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). MCA and DoLS were in place for people in regard to care and treatment, the locked door policy and finances in line with legal requirements. One person had the capacity to leave the premises on their own and staff told us, "The door has a keypad and so we open it for her when she asks" the person confirmed she was able to ask staff to open the door when she wanted to go out.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. Staff identified a person who experienced recurrent urinary tract infections. Records demonstrated that a urine sample had been sent to the GP and as a result the person was prescribed a course of antibiotics. There was evidence that a person who experienced recurrent falls had been provided with equipment and their care plan had been amended to include additional staff support.

Requires Improvement

Is the service caring?

Our findings

People told us they were happy with the care they received. One person said "I really like my keyworker and I can talk to them about anything" another person said "The banter with the staff is lovely."

People's dignity was not respected by staff. We saw staff respond to a person who vocalised loudly by saying "Don't shout there's no need to shout". However staff were seen to shout across the building to their colleagues to ask questions or get their attention. Staff shouted across the dining room to people, asking them if they were alright and saying to one person, "Can you drink your drink up please?" Staff were heard to shout for a colleague to go after a person.

People were called by informal pet names to develop rapport but this had not been reflected in their care plans. Staff were observed to use the terms "good lad", "good boy", "darling" "hello sweetie" and "Hi, alright mate?" during the inspection. This was not consistent with the preferred names identified in peoples care plans. A visitor said that they had seen a mature man being called a 'good boy' and that they felt this was disrespectful.

An action plan was in place as the outcome of a safeguarding meeting with social services. It had identified that appropriate and positive language should be used within care plans and when dealing with people to maintain their dignity.

People were not able to leave the dining table after eating their meal until staff gave them permission. At lunch time we saw people were called by name and told "you may leave the table." The team leader said there was no rationale for this and it had always been done this way. The following day staff had changed their approach and said to people "Would you like to go to the lounge when you are ready?"

People were not given choice or explanations they needed, at the time they needed them. One person was eating a sandwich but was not offered or given a drink with their meal. The person was given a drink after their meal and said "Oh a nice cup of tea, I didn't know they were going to give me one". One person asked where the roast potatoes were as they were on the menu, and a member of staff said there were no roast potatoes because there was no oil left. Staff told us "We asked the residents if they wanted mash and they all agreed".

Some people, or their relatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. We saw three individual profiles that were signed to show that people had been involved in care planning and reviews.
People with communication and sensory needs were not supported to express their views or preferences. Care plans contained pictures of people's food preferences but this was not used to inform menu or meal choices. There was not a system in place to support non-verbal people to say how they felt about the caring approach of the service. One person who used a hearing aid did not have it in place. When staff were asked about this there was been confusion about whether the device was broken, lost or being fixed.

These failures to protect people's dignity and respect them as individuals living in their own home is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff had built caring relations with people and had a good knowledge of their life history which enabled them to provide personalised care. Staff told us "Their family choose not to have contact. They requested to do some knitting so I've brought in wool and needles" and "They go to Headway every Wednesday. They have a son that visits once a month. They like to go for drives to see land and sheep."

Requires Improvement

Is the service responsive?

Our findings

People's rooms were decorated with their choice of ornaments and photos. One person was creative and made pieces of art and their artwork was displayed in their room, another person told us "I was able to choose these decorative lamps and have the room the way I like it." Staff told us they had supported a person by taking them shopping to buy new furniture for their room.

People were able to attend monthly meetings to discuss agenda items including activities, food and events. Minutes of the meetings that had taken place were provided however only 1 meeting had taken place in the last 5 months. The minutes showed people were asked to make suggestions regarding the menu, activities and to raise any concerns they may have.

People told us they had a keyworker. A key worker is a named member of staff that was responsible for ensuring people's care needs were met. This included supporting them with activities and weekly meetings for people to express their views.

Pre-admission assessments were completed by the consultant psychiatrist and a general assessment of all aspects of care and support needs. We saw that the care plans had been reviewed one month after admission as stated in the plan. People's preferences and needs regarding personal care had been clearly recorded including preferences for the gender of support staff. One person told us they often felt anxious when attending healthcare appointments, there was evidence in the person's care plan that this had been recorded and included guidelines for supporting the person to attend appointments.

Where a person's health had changed staff worked with other professionals to ensure that they received appropriate healthcare. We saw records of weekly multi-disciplinary team meetings that took place to discuss and review the needs of all the residents. The team included a psychologist, assistant psychologist, psychiatrist, Occupational Therapist, and the team leaders. Staff also had access to the Positive Behaviour Support team from the Craegmoor Group who advised on distraction techniques and managing behaviour.

People were not offered activities based on their likes and preferences. One person said "[The] only thing that could be better is more outings" and a relative told us "sometimes there is loud music playing and my [relative] told me they were trying to block it out." Activities were not planned or provided in a personalised way. People did not have individual activity plans, a rolling one week activity plan was in place which did not cater to all people but included recurring activities for specific individuals. The regional manager had stated an activity and therapy coordinator would be employed as an outcome of the safeguarding action plan but this was still in progress. Following the inspection an activity coordinator was employed and in post.

Care plans did not include sufficient information to monitor the health and wellbeing of the person. One care plan identified a person was at risk of developing pressure sores and a pressure relieving mattress was in place to reduce the risk of pressure sores. However, the home did not have equipment or a system for regularly checking and recording their weight, which meant that they were unable to ensure that the air pressure of the mattress was correct. The provider took immediate action to order equipment to weigh the

person and charts for monitoring and recording the weight of the person and pressure of the mattress were implemented.

People told us "I have no complaints" and "If I had to [complain] I would tell [keyworker] who would take it to the top dog." A relative told us they had raised concerns which were being addressed. However, people and visitors did not have access to accurate information to be able to report complaints. The complaints policy on display was not current, it had incorrect contact information and some contact details were missing. There was not a system in place to record complaints or how complaints had been resolved, so it was not possible to identify if complaints had been made or if people and their relatives were satisfied with how complaints were dealt with. The service was not monitoring complaints over time in order to address any trends or areas of risk that may need attention. The complaints procedure was not publicised or displayed in accordance with the service Complaints Policy.

The lack of an effective system for receiving, recording and handling complaints is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The previous registered manager had left and de-registered in July 2015. A replacement had been found but was not able to commence employment. A registered manager had not been in post for 10 months. The organisation and management had not provided sufficient support to staff in the absence of a registered manager. Interim management had not been put in place and team leaders were covering the registered manager role in addition to their daily duties and responsibilities. The two weekly visits by the acquired brain injury quality lead and weekly contact with the regional manager were not enough to ensure systems and process were established and compliant with the regulations of the Health and Social Care Act. The team leaders told us that they received support but did not feel they had the skills and time needed to cover the role and responsibilities of the registered manager. This was fed back to the regional manager and head of quality assurance during the inspection .

Internal audits were not consistently completed and where they had identified shortfalls it did not record if action had been taken. For example, their internal kitchen audit had identified a bulb needed to be replaced. The team leader told us, "We will know it has been done because it won't be on the next audit." This meant that there was a potential risk to people because health and safety concerns were not being monitored and responded to in a timely way. Maintenance records were kept of work that had been undertaken and that staff requests for repairs were undertaken but this was not related to the audits that took place. The domestic kitchen cleaning daily checklist was not being signed and had not been completed at all from 31 May to 2 June. There was a risk to people's health because it was not possible to establish if the required cleaning had taken place. The monthly housekeeping audits were blank and the last monthly inspection of beds was undertaken April 2016.
There was not an effective system for staff to follow when a need for action had been identified. The provider did not have effective systems in place to carry out health and safety checks. A Legionella risk assessment identified the home was at high risk of Legionella and set out an action plan for monthly and annual checks. The most recent legionella check we found on file took place 16 April 2014. The water outlet temperatures were being regularly tested and recorded but there was no guidance for staff action to take when the temperature was above or below the guidelines stated on the form.

The lack of a registered manager and of interim management meant there was not an effective management structure in place carry to out the safeguarding action plan. The action plan had identified concerns and agreed actions to appropriately manage or reduce the risks. The concerns included concerns around isolation used as a punitive measure; unreported injuries sustained; poor management of falls; poor management of diabetes; routines and staff knowledge not being consistent to people's needs; and appropriate and positive language should be used within care plans and when dealing with people to maintain their dignity. Training to improve staff knowledge had not been implemented and recruitment for the activity and therapy coordinator was ongoing at the time of inspection. Staff were on the waiting list for Mental Capacity Act training, acquired brain injury training was due for 18 out of 20 staff but dates had not been scheduled for it to take place.
Some records had not been kept up to date or lacked guidance for staff to be able to support people in an emergency. Three of the Personal Emergency Evacuation Plans (PEEPs) had information about how to

support individuals in terms of language and behaviours but the rest contained generic phrases such as the person, 'has always been compliant during fire evacuation drills'. Not all PEEPs were signed, and one had not been reviewed since 3 October 2015. The register of fire marshals included names of staff that had left.

There was not an effective management structure in place for staff to receive adequate supervision and competencies were not consistently reviewed. The member of staff responsible for the controlled drugs error had not received any supervision from January 2016 to the date of the inspection.
Staff feedback was not consistently responded to. Staff had fed back during meetings last year that they needed a shed for the garden furniture, this had recently been provided. However staff requests for a sheltered smoking area for people to use in bad weather and wheelchair access to the garden patio had not been acted upon.

The service was not able to demonstrate how it sought the views of staff, residents and relatives through surveys or if their views were acted upon to improve their experience of the service.

There were failures to operate an effective quality monitoring system which recognised areas for improvements and led to action. Along with a failure to maintain accurate, up to date and fit for purpose records relevant to each person and the operation of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The head of quality assurance advised the service was in the process of transitioning from physical intervention to Positive Range of Options to Avoid Crisis and use Therapy, Strategies for Crisis Intervention and Prevention (PROACT SCIP). The model of PROACT SCIP follows the positive behaviour support model and its focus is on proactive methods to avoid triggers that may lead to a person to present behavioural challenges to get their needs met. It aims to support staff to identify triggers and recognise early behavioural indicators, so that non-physical interventions can be used to prevent a crisis from occurring. It's aim is to enhance a person's quality of life and give people the skills to communicate their own needs, rather than present with a behavioural challenge. There was not a timescale to indicate when people at the service would be able to benefit from this new approach.

Policies and procedures were available for staff to support practice. There was a whistle blowing policy and staff were aware of their responsibility to report any bad practice.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not being treated with dignity and respect at all times. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person was not ensuring safe and effective processes for the proper and safe management of medicines.The provider did not appropriately identify, and manage risks relating to the health, safety and welfare of people. The risk assessments did not have comprehensive plans for managing risks. Regulation 12 (2) (a) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment. This a breach of the Health and Social Care Act 2008 Regulation 13 (1) (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 16 HSCA RA Regulations 2014

personal care	Receiving and acting on complaints The registered person had not established and operated an effective system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to carrying on of the regulated activity. Regulation 16 (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes had not established to assess, monitor and mitigate risk relating to the health, safety and welfare of service users. Maintain an accurate, complete and contemporaneous record in respect of each service user. Evaluate and improve their practice in respect of their audit and governance systems. 17 (1) (2)(a)(c)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service and keep them safe at all times. The provider had not ensured that staff were suitably trained and competent to provide safe and appropriate care. Regulation 18 (1) (2)(a)